

Wisconsin Health Insurance Risk Sharing Plan (HIRSP)
Health Insurance
Medical Adjustment Request Form

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| | | | | | | | | | | |
| 1. PROVIDER NAME | 2. PROVIDER NUMBER | | | | | | | | | |

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|-------------|--|----------------------|--|
| 3. R/S DATE | | 5. POLICYHOLDER NAME | |
|-------------|--|----------------------|--|

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| 4. CLAIM NUMBER | 6. POLICYHOLDER NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

7. PAYEE ☐ PROVIDER
 ☐ POLICYHOLDER

- ☐ ADD NEW DETAIL(S) ON PREVIOUSLY PAID/ALLOWED CLAIM: (In 8, enter information to be added).
- ☐ CORRECT DETAIL ON PREVIOUSLY PAID/ALLOWED CLAIM: (In 8, enter information as it appears on R/S Report).

8. ENTER INFORMATION FROM CLAIM AND R/S REPORT

| DATES OF SERVICE | | POS | TOS | PROCEDURE/REVENUE | | | BILLED | UNIT | EMG | PERFORMING PROVIDER |
|------------------|----|-----|-----|-------------------|-----|-----|--------|------|-----|---------------------|
| FROM | TO | | | CODE | MOD | MOD | | | | |
| | | | | | | | | | | |
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9. REASON FOR ADJUSTMENT

- ☐ RECOUP ENTIRE PAYMENT.
- ☐ OTHER INSURANCE PAYMENT \$ _____ (OI-P).
- ☐ MEDICARE RECONSIDERATION (EOMBs ATTACHED).
- ☐ CORRECT DETAIL (Enter information in 8 as it appears on R/S Report. Enter correct information below.).
- ☐ OTHER/COMMENTS:

10. SIGNATURE

11. DATE

MAIL TO: HIRSP
 6406 BRIDGE ROAD, SUITE 18
 MADISON, WI 53784-0018

12. ☐ CLAIM FORM ATTACHED (OPTIONAL)